Benefits at a Glance	**Open Access Plus – High (OAP-High)** **Managed by CIGNA HealthCare**	
	In-Network	**Out-of-Network**
Physician Network Area	National	
Plan Contact Information	CIGNA Customer Service: 800-244-6224 Website: www.cigna.com; www.mycigna.com	
Primary Care Physician (PCP)	Not required.	
Referrals for Specialty Care	Not required.	
Annual Deductible	$0	$250 individual / $500 family
Yearly Out-of-Pocket Limit	$0	$3000 individual / $6000 family
Office Visits (PCP/ Specialist)	Covered in full after $15 copay for primary care physician; $25 copay for specialist.	Covered at 70% of plan allowance after deductible.
Preventive Care (Children and Adults)	Covered in full. Refer to Benefits page on FairfaxNet for list of services.	Children through age 18: 70% of allowed benefit; no deductible. Age 18 and above: 70% of allowed benefit; after deductible. Refer to Benefits page on FairfaxNet for list of services.
Inpatient Hospital Care/ Doctor's Services	Covered in full after $100 per admission copay.	Covered at 70% of plan allowance after deductible.
Laboratory & X-Ray	Covered in full at physician's office after PCP or Specialist copay. Advanced Radiology: Covered in full after $75 copay at radiology centers or outpatient department of hospital.	Covered at 70% of plan allowance after deductible.
Prescription Deductible	$0	
Prescription Out-of-Pocket Max	N/A	
Prescription Drugs	*Retail (up to 30-day supply):* $7 copay for generic $30 copay for brand formulary $50 copay for brand non-formulary *Mail Order (up to 90-day supply):* $14 copay for generic $60 copay for brand formulary $100 copay for brand non-formulary	*Retail (up to 30-day supply):* Covered at 70% of allowed benefit; no deductible *Mail Order (up to 90-day supply):* Not Covered
Maternity Care	Covered in full after initial $15 copay for primary care physician or $25 copay for specialist to confirm pregnancy.	Covered at 70% of plan allowance after deductible.
Emergency Treatment	Covered in full after $150 copay for emergency services (waived if admitted for treatment other than observation).	Covered in full after $150 copay for emergency services (waived if admitted for treatment other than observation).
Urgent Care	Covered in full after $25 per copay (waived if admitted for treatment other than observation).	Covered in full after $25 per copay (waived if admitted for treatment other than observation).
Mental Health and Substance Abuse Treatment	*Inpatient* – Covered in full after $100 per admission copay. *Outpatient* – Covered in full after $15 copay.	*Inpatient* – Covered at 70% of plan allowance after deductible. *Outpatient* – Covered at 70% of plan allowance after deductible.
Infertility Coverage	Covers testing/treatment for underlying medical condition, diagnosis, medical/surgical treatment to restore fertility & artificial insemination. $15/$25 copay for office visit; $25 copay for facility visit. Includes IVF, GIFT, ZIFT, etc. $30,000 maximum per calendar year. $100,000 lifetime maximum (combined in-network and out-of-network).	Covered at 70% of plan allowance after deductible. Covers testing and treatment for underlying medical condition, diagnosis, medical/surgical treatment to restore fertility & artificial insemination. Includes, IVF, GIFT, ZIFT, etc. $30,000 maximum per calendar year. $100,000 lifetime maximum (combined in-network and out-of-network).
TMJ, surgical and non-surgical • **Non-surgical services subject to a $600 lifetime maximum.**	Covered in full after $15 copay for primary care physician; $25 co-pay for specialist. Inpatient $100 copay per admission. Outpatient Facility covered in full after $25 co-pay per visit.	Covered at 70% of allowed benefit after deductible.

Benefits at a Glance	**Open Access Plus – High (OAP-High)** **Managed by CIGNA HealthCare**	
	In-Network	**Out-of-Network**
Hearing Aids • **Maximum benefit is $2800 every 36 months (combined in-network and out-of-network).**	Covered in full.	Covered at 70% of allowed benefit after deductible.
Wigs • **Based on medical necessity** • **$350 maximum per calendar year**	Covered in full.	Covered at 70% of allowed benefit after deductible.
Dental Care (additional coverage available through Delta Dental plan – separate premium required)	Routine care not covered.	
Routine Vision Care	Vision benefits provided through Davis Vision.	